CONSENT FORM FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION

****Before medication can be administered by CER program personnel this form must be completed and on file****

Child's Name: ____ Birth Date: _______________

Program Site: ____ Grade: __________________

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PHYSICIAN / LICENSED PRESCRIBER ORDER

Epinephrine auto-injector type: __________________________ Dose: ☐ 0.15 mg IM **or** ☐ 0.3 mg IM

Instructions for giving medication: ____

Criteria for repeat dosing: ____

Possible side effects: ____

Other/Additional Directions: ____

Emergency Allergy Medication should be administered for the following type(s) of symptoms:

☐ __MOUTH	☐ __SKIN	☐ GUT	☐ __THROAT	☐ __LUNGS	☐ __HEART	☐ __OTHER
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	feeling something bad is about to happen, anxiety, confusion

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.

PHYSICIAN/LICENSED PRESCRIBER SIGNATURE: ______________________________ Date: _______

Print Name: ____________________________________ Clinic: ____________________________

Phone #: __________________________ Fax #: _______________________

OVER

Child's Name: ________________________

PARENT/GUARDIAN AUTHORIZATION

1. I request the above medication be given to my child during CER program hours by CER program staff as ordered by the physician/licensed prescriber.
2. I will provide this medication in the original, properly labeled pharmacy container.
3. I authorize the CER Program Coordinator/designee to exchange information with my child's healthcare provider concerning any questions that arise with regard to the listed medication, medical condition, emergency plan, or side effects of this medication.
4. I authorize the CER Program Coordinator/designee to communicate with appropriate CER program personnel regarding this medication and emergency care plan for my child.
5. I release CER program personnel from any liability in relation to the administration of this medication during the program.
6. I have read and understand the Medication Guidelines included with this form (below).

Parent/Guardian Signature:___________________________________ Date:__________________

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GUIDELINES FOR ADMINISTRATION OF EMERGENCY ALLERGY MEDICATION

The administration of medication to students shall be done only in exceptional circumstances wherein the student's health may be jeopardized without it.

1. Administration of Emergency Allergy Medication by school personnel will only be done according to the written order of a physician/licensed prescriber and written authorization of parent/guardian.
    a. Altered forms of medication will not be accepted or administered during a CER program.
    b. Narcotics/medical cannabis will not be administered at CER program.
    c. Aspirin-containing products will not be administered at CER program.
    d. Only FDA approved treatments will be provided at CER program.
2. A new medication consent form is required year and when the medication dosage or instructions for administering the medication are changed.
3. If the medication is discontinued, a physician/licensed prescriber is requested.
4. The medication must be brought to and from CER program by a parent/guardian in its original container.
5. The following information must be on the medication container:
    a. Child's full name
    b. Name and dosage of medication
    c. Directions for administration must match the authorization form
    d. Physician/Licensed Prescriber name
    e. Date (must be current)
6. Medications are not to be carried by the child and will be kept in a locked box/cabinet designated for medication.